Transgender Resource and Referral List Information Form

Please use this form to add your organization's information to the first edition of the Transgender Resource and Referral List. We want to provide our clients with the best possible services and your help is crucial. Information on this form will be provided to anyone requesting the Transgender Resource & Referral.

_____

Name of Individual or Organization | Area Served

_____

Address | City/County, State, Zip

_____

Telephone | Fax | Hotline if applicable

_____

Days and hours of operation | E-mail address and/or website

Do you accept walk-ins? YES____ NO ____
Is there a waiting list for services? YES____ NO ____ If Yes, how long? _____

Services

Which of the following services do you provide for your transgender clients?

___ Primary care services
___ Dental services
___ Psychiatric services
___ Psychological evaluation
___ Other (please list) _____
___ Hormone therapy
___ Support services
___ Psychotherapy & Counseling (circle: individual / group)
___ OB/GYN services
___ Legal services
___ Laser hair removal and/or electrolysis

Surgical Procedures

Which of the following surgical procedures do you provide for your transgender clients?

___ Genital Reassignment Surgery (GRS) for Male to Female (MTF) transsexuals
___ Genital Reassignment Surgery (GRS) for Female to Male (FTM) transsexuals
___ Chest surgery for FTMs
___ Breast augmentation for MTFs
___ Other cosmetic procedures (please list) _____

Payment

Is there a sliding fee scale available? YES ____ NO ____
Is full fee required at time of services? YES ____ NO ____
Do you accept Medicaid? YES ____ NO ____
Do you accept Medicare? YES ____ NO ____ If yes, are there any restrictions? (please list) _____
What insurance plans, if any, does your facility accept?_____

Please check the statements below that are true for you and/or your agency:

___ I am currently licensed in the jurisdiction in which I offer service(s).
___ I am willing to provide services pro bono to a number of clients that I specify.
___ I am cognizant of the Ethical Principles and Standards for my profession.
___ I am familiar with the Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders.

How long and in what capacity have you worked with the transgender population?

_____

_____

How did you receive your training/knowledge of the transgender population?

_____

_____

What methods did/do you use to build up your clientele?

_____

_____

To whom do you refer clients for care that you do not provide?

_____

_____

How do clients find out about your services?

_____

_____

To the best of your knowledge, are there other providers in your area that offer services similar to yours?

_____

What is the biggest obstacle for you in providing care to transgender individuals?

_____

What licenses do you currently hold?

_____

Do you provide services to transgender youth clients? If so, please list services.

_____

Do you have persons on site who speak languages other than English? If yes, please list languages.

_____

Do you have transgender staff? YES ___ NO ___

Do you have handicap access to your facility? YES ___ NO ___

_____ _____ - _____ - _____

Name and title of contact person Telephone

Please return this form to:

Virginia Department of Health, Division of Disease Prevention
ATTN: Ami Gandhi
Transgender Resource and Referral List
P.O. Box 2448, Room 326
Richmond, VA 23218-2448
Contact Number: 804-864-8002
Fax: 804-864-8053